

The Medical Plan provides benefits for medical coverage. Enrollment in the Medical Plan is optional. The medical programs and related health benefits available under the Medical Plan are generally described in this section of the booklet as well as in the Certificates of Coverage issued by Aetna. Taken together, this booklet section and the Certificates of Coverage constitute the official Summary Plan Description (“SPD”) for the Medical Plan. **Please note that the Employer reserves the right to amend or terminate this Medical Plan at any time and for any reason.**

You can find copies of this booklet, the Certificates of Coverage and any future Medical Plan Amendments at: <http://www.bnl.gov/hr/Benefits>.

WHO IS ELIGIBLE FOR THE MEDICAL PLAN?

Enrollment in the Medical Plan is optional and is open to only those employees, retirees, and participants receiving BSA Long Term Disability (LTD) Plan benefits (and their eligible dependents) who are otherwise eligible to enroll in the Medical Plan as described below.

Active Employees

All regular employees of Brookhaven Science Associates, LLC (the “Employer”) who work at least 20 hours per week are eligible to participate in the group Medical Plan on the first day of active employment.

An employee is a “regular employee” if he/she is classified and treated for federal income tax purposes by the Employer as a regular full-time or regular part-time employee of the Employer (as opposed to a temporary, seasonal or casual employee, intern, independent contractor or consultant, agency worker or leased employee), even if the Employer’s classification is later determined to be incorrect.

Based on the terms of the Affordable Care Act (ACA) – also known as National Health Care Reform, beginning on January 1, 2014, eligible employees who are employed on a temporary basis, who work an average of 30 or more hours per week and are employed for 90 days or more may be eligible to enroll in the Medical Program on the 90th day of employment. Additional ACA criteria may apply.

Ineligible Employees

The following employees are not eligible for the Medical Plan:

- Employees who are resident undocumented aliens; and
- Employees whose terms of employment are covered by a collective bargaining agreement to which the Employer is a party, unless the collective bargaining agreement provides otherwise.

Eligible Dependents

The following members of your family are also eligible for Medical Plan coverage:

- Your spouse (which may include your same-sex spouse) to whom you are legally married.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). If you are living in a jurisdiction that recognizes same-sex marriage, you must be married and provide a copy of your marriage certificate. If you live in a jurisdiction that does not recognize same-sex marriage, you must provide a copy of your (a) civil union registry, (b) domestic partner registry, or (c) a completed Affidavit of Domestic Partnership and provide proof of financial interdependence. Additional information is available at <http://www.bnl.gov/hr/Benefits/DomesticPartners.asp>. Children of your eligible domestic partner must meet the same criteria for a "child" under the Medical Plan.
- Your child(ren) up to the end of the calendar month of his or her 26th birthday, including your natural children, adopted children and stepchildren.
- Coverage may be continued for your eligible dependents who are age 26 or over and who are or become mentally or physically incapable of earning their own living while covered as an eligible dependent, by submitting proof of the child's incapacity within 31 days from the date of incapacity or 31 days from the child's 26th birthday, whichever occurs first. The insurance company will review the information submitted and will either approve or deny such coverage.

When a dependent is no longer eligible for coverage, you should contact the BSA Benefits Office to remove him or her. If you do not timely notify the BSA Benefits Office, you will be required to reimburse the Medical Plan for any benefits paid on behalf of an ineligible dependent and may be subject to further sanctions if your failure was willful.

Your dependents can become eligible for dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your dependent

provided you timely enroll him or her as described below.

Dependents of Deceased Participants

If you are participating in the Medical Plan and are not eligible for retiree medical coverage, and you die while in active service, while on an authorized leave of absence or while receiving LTD Plan benefits, your covered dependents may continue in the Medical Plan under the COBRA provisions to the extent they are eligible by paying the applicable COBRA cost for such coverage. See the "COBRA" section for additional information.

If you are participating in the Medical Plan and are eligible for retiree medical coverage, and you die while in active service, while on an authorized leave of absence, or while receiving LTD Plan benefits, your covered dependents may continue in the Medical Plan by paying the required retiree premiums for as long as they are eligible. If you have a surviving spouse, the surviving spouse must elect Medical Plan coverage in order for your other covered dependents to continue in the Medical Plan.

See the "Termination of Coverage" section for information on when your coverage will terminate. In addition, coverage for dependents will terminate on the date the surviving spouse remarries.

Coverage under COBRA will be offered in accordance with the law.

LTD Plan Participants

All terminated employees receiving LTD Plan benefits and who are participating in the Medical Plan immediately prior to receiving LTD Plan benefits (but who are not the covered dependent of another person who is enrolled in the BSA Medical Plan or the BSA Health Reimbursement Account Program) and who are not Medicare-Eligible may participate in the Medical Plan with their covered dependents who are not Medicare-Eligible by paying the required LTD Plan participant premiums. However, an LTD Plan participant includes all terminated employees receiving LTD Plan benefits who are Medicare-Eligible and were approved for such LTD Plan benefits prior to January 1, 2009 (January 1, 2012, in the case of a terminated employee who was covered under a collective bargaining agreement between the Employer and the International Brotherhood of Electrical Workers (IBEW)) and is receiving such LTD Plan benefits.

Retirees

All employees who are participating in the Medical Plan (but who are not the covered dependent of another person who is enrolled in the BSA Medical Plan or the BSA Health Reimbursement Account Program) who are not Medicare-Eligible and who terminate employment after attaining age 55 and have a combination of age and years of Continuous Service immediately prior to retirement (10 years minimum, or for employees hired prior to January 1, 2001, 5 years minimum) that total 70 years or more may participate in the Medical Plan with their covered dependents by paying the required retiree premiums. For example: An employee age 55 would be eligible for retiree medical coverage after 15 years of Continuous Service. A 62 year old employee would be eligible after 10 years of Continuous Service, if hired on or after January 1, 2001. A 62 year old employee would be eligible after 8 years of Continuous Service, if hired before January 1, 2001.

In determining eligibility for retiree medical coverage, employees who are hired by the Employer in connection with the National Synchrotron Light Source II ("NSLSII") project may receive credit for their service with their prior employer in calculating their years of Continuous Service. This prior service credit applies to (a) employees permanently hired by the Employer on or after October 1, 2005 to work on the NSLSII project, or (b) spouses of employees permanently hired by the Employer on or after October 1, 2005 to work on the NSLSII project, if the spouse is permanently hired by the Employer on or after October 1, 2005, even if the spouse is not hired to work on the NSLSII project. The prior service credit applies only to service with a laboratory operated under a contract with the Department of Energy, and only if the employee or spouse was employed by that laboratory immediately before he or she was hired by the Employer. For example, if an employee is hired by the Employer to work on the NSLSII project on January 1, 2006, and before being hired by the Employer was employed with another laboratory operated by an entity under a contract with the Department of Energy since January 1, 2000, the employee will have six years of Continuous Service when he or she begins at the Employer.

Also, employees who are participating in the Medical Plan who are not Medicare-Eligible and who terminate employment after completing 35 years of Continuous Service may participate in the Medical Plan with their covered dependents by paying the required retiree premiums.

Notwithstanding anything to the contrary, when LTD Plan benefits cease for a participant who was receiving such LTD Plan benefits and who was participating in the Medical Plan during his or her period of covered disability, the participant's Continuous Service credited prior to the

commencement of LTD Plan benefits and his or her age at the time the LTD Plan benefits cease are used for determining eligibility for retiree medical benefits under the Medical Plan.

You may not retire directly from a Leave of Absence. You must return from the Leave to active employment for a minimum of 30 days and then meet the criteria for retiree medical coverage. This requirement does not apply to participants who are receiving LTD Plan benefits or participants who are on a joint appointment approved by BSA.

Retirees otherwise eligible who are subsequently employed elsewhere or have coverage available through their spouse's employer may suspend their retiree medical coverage through the Employer. It may only be reinstated during an Open Enrollment Period (effective January 1 of the following calendar year) or when a Qualifying Event occurs.

As of January 1, 2007, eligible employees in the positions indicated below who are participating in the Medical Plan and are not Medicare-Eligible and who terminate employment after attaining age 50 and have 25 years or more of Continuous Service may participate in the Medical Plan with their covered dependents by paying the required retiree premiums. If Continuous Service is at least 20 years but less than 25 years and all other criteria indicated above are met, such eligible employees may participate in the Medical Plan by paying the COBRA cost of the Medical Plan until their age plus Continuous Service immediately prior to retirement plus their age total 75 years or more (at which time they can continue coverage by paying the required retiree premium). For the purpose of this paragraph, positions eligible for such coverage include Fire Chief, Deputy Fire Chief, Fire Captain, Police Chief, Police Captain, Police Lieutenant and Police Security Training Instructor.

If you are participating in the Medical Plan and you die while on retiree medical coverage, your covered dependents may continue in the Medical Plan by paying the required retiree premiums.

If you die while your benefits are in a suspended status, your eligible dependents may also reinstate coverage during an Open Enrollment Period or when a Qualifying Event occurs.

ENROLLMENT

Eligible employees may enroll in one of the medical programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or until you have a Qualifying Event to elect coverage. For additional information, see the "Qualifying Events" section.

To enroll, you must complete an enrollment form and list all eligible dependents you want covered, including each dependent's Social Security Number and date of birth. You must provide a marriage certificate for a spouse, proof of domestic partnership for a domestic partner, and a birth or adoption certificate for a child. Enrollment forms are available through the BSA Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only
- Employee and one dependent
- Employee and two or more dependents

You cannot enroll your eligible dependents without also enrolling yourself for medical coverage. You cannot enroll your dependents in a different medical program than you have selected for yourself.

Coverage begins on your date of hire if you complete the enrollment form and submit it to the BSA Benefits Office within 30 days of your date of hire.

NOTE: If both you and your spouse (or same-sex domestic partner) are eligible to enroll under the Medical Plan or HRA:

- The spouse(or same-sex domestic partner) may enroll for his/her own coverage, or
- The spouse (or same-sex domestic partner) may enroll as a dependent on your coverage (or vice versa).
- If you and your spouse (or same-sex domestic partner) enroll separately for coverage, you may not enroll each other on the coverage.
- If you and your spouse (or same-sex domestic partner) enroll separately for coverage, children may be covered as the dependents of either parent, but not both parents.

Open Enrollment Period

Open enrollment is held once a year. During an Open Enrollment Period, you may change medical programs, drop coverage and/or add or drop eligible dependents from your coverage. Employees who did not previously elect medical coverage (or retirees who previously suspended enrollment due to other coverage) may elect it during the Open Enrollment Period online or by paper form. Participants receiving LTD Plan benefits who are terminated from employment, retirees, and their dependents who did not previously elect medical coverage, may not elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections cannot be changed for the remainder of the calendar year unless you notify the BSA Benefits Office of a Qualifying Event within 31 days of the event.

Qualifying Event

A Qualifying Event that allows you to add or drop coverage is a change in your family status or employment status that affects your need for medical coverage. This includes:

- (a) Change in legal marital status
 1. marriage
 2. death of spouse
 3. divorce
 4. legal separation
 5. annulment
- (b) Change in the number of dependents
 1. birth
 2. adoption
 3. placement for adoption
 4. death of a dependent
 5. entering into or terminating a same-sex domestic partnership
- (c) Change in employment status
 1. termination or commencement of employment of the employee, spouse, same-sex domestic partner or dependent (other than for termination of the employee for misconduct)

- (d) Changes in work schedule
 - 1. an increase or decrease in the number of hours of employment by the employee, spouse, same-sex domestic partner or dependent
 - 2. a switch between full-time and part-time status
 - 3. a strike or lockout
 - 4. commencement or return from an unpaid leave of absence
- (e) The dependent satisfies or ceases to satisfy the requirements for dependent coverage
 - 1. attainment of age
 - 2. student status
- (f) A change in the place of residence or work site of the employee, spouse, same-sex domestic partner or dependent

In addition, under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), employees and dependents that are eligible but not enrolled in the Medical Plan may enroll for coverage if one the following conditions is met:

- The employee or dependent loses eligibility and is terminated from Medicaid or CHIP* coverage or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP*.

*CHIP (Children's Health Insurance Program) is a state program designed to provide health care coverage for uninsured children and some adults.

You have 31 days from the date of a Qualifying Event to make changes to your medical coverage for all items indicated above except (a)(3), (a)(4), and (e)(1). You have 60 days from the date of a Qualifying Event to make changes to your medical coverage for items (a)(3), (a)(4), (e)(1), and for changes related to CHIPRA. The change requested must relate to the change that affects eligibility for medical coverage. Changes are made by completing an enrollment form, available in the BSA Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the BSA Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as soon as administratively feasible after the Plan Administrator has approved the change in status, except that a new child may be added as of the date of birth, date of adoption or date of placement for adoption.

If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, separation, annulment or custody change requires your dependent child to be covered under this Medical Plan, you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

If the Plan Administrator notifies you that the cost of your coverage under the Medical Plan significantly increases during the Plan Year or there is a significant curtailment of coverage mid-year, you will have the opportunity to stop or change your coverage as permitted by the Plan Administrator.

If you do not make a change to your medical coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period.

MEDICAL PROGRAMS AVAILABLE

Medical Programs Available	Eligible Participants and Their Covered Dependents
Aetna POS Plan 1 Aetna POS Plan 2 Aetna POS Plan 3	<ul style="list-style-type: none"> • Active Employees • Non-Medicare eligible retirees • Medicare-Eligible retirees residing outside the United States • Non-Medicare eligible participants who are receiving BSA LTD Plan benefits • Medicare-Eligible participants who are receiving BSA LTD Plan benefits who were approved for such LTD Plan benefits prior to January 1, 2009 (January 1, 2012 for former IBEW employees) • Medicare-Eligible participants who are receiving BSA LTD Plan benefits residing outside the United States • DWMBP* participants • COBRA participants
Aetna Plan 4 HDHP with HSA	<ul style="list-style-type: none"> • Active Employees who are under age 65

*Displaced Workers Medical Benefits Protection Act

See the “General Description of Medical Plan Programs” section for a general description on the benefits. For a more complete discussion of the terms and conditions of the various medical programs offered under the Medical Plan, please refer to the Certificate of Coverage for the particular Medical Plan program.

PLAN’S RIGHTS OF RECOVERY, SUBROGATION AND REIMBURSEMENT

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties (not an exhaustive list):

- a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- any person or entity who is or may be obligated to provide you with benefits or payments under:
 - underinsured or uninsured motorist insurance;
 - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
 - workers' compensation coverage; or
 - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

By participating in and receiving benefits under the Medical Plan, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter

how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- regardless of whether you have been fully compensated or made whole, the Plan may collect from you, your representative or a third-party payor the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- benefits paid by the Plan may also be considered to be benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
 - complying with the terms of this section;
 - providing any relevant information requested;
 - signing and/or delivering documents at its request;
 - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - responding to requests for information about any accident or injuries;
 - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
 - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a sickness, injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may file suit in your name and take appropriate action to assert its rights under this section. Even if it files suit in your name, the Plan is not required to pay you part of any recovery it may obtain from a third party to the extent the recovery does not exceed the Benefits the Plan has provided for a sickness or injury caused by a third party and the costs the Plan incurs in obtaining the recovery. Notwithstanding anything to the contrary in this document, even if it files in your name, the Plan is not required to seek a recovery from the third-party in excess of the Benefits the Plan has provided for a Sickness or Injury caused by a third party and the costs the Plan incurs in obtaining the recovery.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or

guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or offset from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- if any claim is made that any part of the Plan's subrogation, reimbursement and/or offset provisions are ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of these provisions.

It is a federal crime punishable by prison to defraud an ERISA-governed plan. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an ERISA-governed plan, submits an application or files a claim containing a false or deceptive statement is guilty of fraud.

COORDINATION OF BENEFITS

Coverage Under Other Employers' Plans

If you and your covered dependents are eligible to receive benefits under another group medical plan, coordination of benefits is based on the terms of those plans. To make sure you obtain all the benefits available, you and your family members should file claims under each plan. In no event will the combined benefits exceed 100% of the allowable expenses. Additional information about your Medical Plan is provided in the Certificate of Coverage for the particular Medical Plan program.

Medicare

For retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare, the medical programs will not pay for any medical expenses that are eligible for reimbursement under Medicare. Retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare must enroll for both Parts A and B of Medicare when first eligible for Medicare. If the participant does not enroll for Medicare Parts A and B the Medical Plan will reduce benefits as if Medicare coverage is in place. If you are eligible for, but not enrolled in, Medicare, and the Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, benefits will be paid on a secondary basis under the Medical Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. In all cases where a participant is Medicare eligible, the Medicare approved amount is the allowable expense for purposes of the Medical Plan, and in no event will Medicare payments, combined with Medical Plan benefits, exceed 100% of the allowable expense.

CLAIMS AND APPEALS ADMINISTRATOR

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the Claims and Appeals Administrators for the Plan features. As the Plan Administrator's delegates, the Claims and Appeals Administrators have the authority to make decisions relating to benefit claims.

The Plan Administrator has delegated the claim fiduciary responsibilities of the Medical Plan to Aetna. As such, Aetna, in its role as the Claims and Appeals Administrator has the discretion to:

- interpret the terms of the Medical Plan and the benefits defined thereunder;
- interpret the other terms, conditions, limitations and exclusions of any medical program offered under the Medical Plan; and
- make factual determinations related to the Medical Plan program and its benefits.

For a detailed description of the claims and appeals provisions under the Medical Plan and the programs thereunder, please see the Certificate of Coverage for the particular Medical Plan program.

CLAIMS

How to File a Claim

Typically, your medical providers will complete all claims information for your and bill Aetna on your behalf. If your provider does not file a claim for you or you are requesting coverage for an out-of-network benefit you must complete a claim form that is available in the BSA Benefits Office or through the BSA Benefits Office website at: <http://www.bnl.gov/hr/Benefits> and file it with Aetna within 180 days of the date of service.

If you are enrolled in the Medical Plan, covered by Medicare, and retired or receiving LTD Plan benefits and terminated from employment, or a dependent of a retiree or participant receiving LTD Plan benefits who is terminated from employment, you must submit your bills to Medicare first. For items not covered in full by Medicare, submit the explanation of benefits from Medicare, copies of the bills, and a completed claim form to Aetna.

Questions About Claims

If you have a question about your medical and/or prescription drug claims, you should contact Aetna at (855) 586-6961 or at the number and/or address listed on the back of your card.

How to Appeal a Claim

You may request a review of the denied claim in writing to the Claims and Appeals Administrator within 180 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the Claims and Appeals Administrator will render a decision within 30 days of the date your request for review is received. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

The Claims and Appeals Administrator will respond within 60 calendar days after receiving the appeal. If more time or information is needed to make the decision, the Claims and Appeals Administrator will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Independent Review Organization

If your final appeal is denied, you may have the right to have your claims heard by an Independent Review Organization (IRO). This is an organization that will review your claims which is independent of the claims administrator. You should file your claim with the IRO no later than four months following the final denial of your claim. If your claim is urgent, you may file your claim with the IRO following an initial claim denial. For more information on this voluntary level of appeal, and whether your claim is eligible for this no-cost appeal, contact the BSA Benefits Office.

AMENDMENT AND TERMINATION

The Employer reserves the right to amend any one or more of the underlying Medical Plan features, including, but not limited to, any medical program, at any time without the consent of any employee or participant; except that any amount which became payable under the Medical Plan prior to the date an amendment is effective will be paid or payable in accordance with the terms of the Medical Plan as in effect immediately prior to the effective date of the amendment.

The Employer expressly reserves the right to terminate the Medical Plan, in whole or in part, at any time. No Medical Plan participant will have a vested right to any benefit under the Medical Plan. On termination of the Medical Plan, any amounts that became payable under the terms of the Medical Plan prior to the date of termination will be paid in accordance with the terms of the Medical Plan as in effect immediately prior to the date of such termination. Upon the termination of the Medical Plan all elections and reductions in compensation relating to the Medical Plan will terminate.

Medical Plan participants will be notified of any amendment or termination of a Medical Plan feature or of the Medical Plan within a reasonable time; provided, however, that, with respect to mid-year changes, notice of a material reduction in benefits under the Medical Plan will be provided to Medical Plan participants enrolled in the affected benefit at least 60 days prior to the effective date of the amendment.

LEGAL NOTICES

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Women's Breast Cancer

Federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Treatment of physical complications in all stages of mastectomy, including lymphedema.
- Mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

The Medical Plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services are subject to deductibles, co-insurance and co-payment amounts that are consistent with those that apply to other benefits under the Medical Plan.

COST OF THE PLAN

Employee Premiums

Employees who elect to participate in the Medical Plan must pay the required premiums. Your premiums are based on your Base Salary, the cost of the plan you elect, and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

Employee premiums are listed in the "Employee Premiums" section and are subject to change.

Displaced Workers Medical Benefits Protection Act (DWMBP) Premiums

Employees who are terminated from employment as part of a reduction-in-force may continue their medical coverage by paying the required premiums. Premiums during the first year after termination of employment will be the active employee premium based on your Base Salary on the day immediately preceding termination of employment. During the second year, premiums will be one-half of the applicable COBRA premium. After the second year, such participants may continue coverage under COBRA. Premiums are listed in the "Employee Premiums" and "DWMBP Premiums" sections and are subject to change. Such DWMBP benefits as described in this section are not available to participants, their spouse or their dependent child if eligible for Medicare, retiree medical coverage, or for coverage under another employer's group health plan. If a participant is ineligible for DWMBP benefits, they may be eligible to continue coverage under COBRA.

Premiums For Retirees and For Participants Receiving Long Term Disability Plan Benefits Who Are Terminated From Employment

Retiree premiums are listed in the “Retiree Premiums” section and are subject to change.

LTD Plan participant premiums are listed in the “LTD Plan Participant Premiums” section and are subject to change.

You must enroll in Medicare Parts A and B as soon as you become eligible for Medicare. Premiums are affected by many factors including your eligibility for Medicare and the Medicare eligibility of your covered dependents. If you live outside of the United States and are not enrolled for Medicare, the premium for your Medical Plan coverage will be the Medicare Part B premium in addition to any other required Medical Plan premium.

DEFINITIONS

Base Salary

Base Salary for the purpose of the medical programs means your basic rate of pay, before any salary reductions. It does not include overtime, bonuses, or any other compensation. For part-time employees, Base Salary is based on the full-time equivalent basic rate of pay. For union employees, Base Salary is based on the terms of the union contract.

Coinsurance

Coinsurance is your share of the costs of a health care service. It is expressed as a percentage of the covered health care expense, so if the coinsurance is 20%, this means that you pay 20% of the cost of the negotiated or Recognized Charge. The coinsurance is different for in- and out-of-network services.

Continuous Service

Continuous Service means service from your most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on approved Leave of Absence and will not include periods when the employee is not eligible for Medical Plan benefits. Continuous Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute (and for employees hired on or after January 1, 2010 Continuous Service with Battelle-related entities, excluding Department of Energy laboratories managed by Battelle), Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

Deductible

The deductible is the amount of money you pay for covered expenses that must be paid out-of-pocket before the medical program will pay any expenses. Aetna Plans 1 - 3 have separate deductibles for medical expenses and prescription drug expenses. In Aetna Plan 4, the deductible is combined for medical expenses and prescription drug expenses. Once an individual or family has met the calendar year in-network deductible, then no further in-network deductible is required for the remainder of the calendar year. Once an individual or family has met the calendar year out-of-network deductible, then no further out-of-network deductible is

required for the remainder of the calendar year. The deductible is different for in- and out-of-network services.

Medicare-Eligible

Medicare-Eligible means the person is eligible to receive benefits under Medicare, due to age or disability, or would be eligible to receive such benefits upon application therefore; provided, however, that a person shall be Medicare-Eligible as of the first day of the month he or she attains age 65, or the first day of the prior month if born on the first day of a month or the first day of the month he or she becomes eligible due to disability, regardless of whether such person actually applies for or is eligible to receive Medicare benefits at that time.

Out-Of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of money you will pay for covered medical services in a calendar year. The out-of-pocket maximum includes copayments, deductibles and coinsurance. The out-of-pocket maximum is different for in- and out-of-network services.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order (QMCSO) is issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under this Medical Plan;
- Name and last known address of each child to be covered under this Medical Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Medical Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Medical Plan. As a beneficiary covered under the Medical Plan, your child will be entitled to information that the Medical Plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Information on the administration of a Qualified Medical Child Support Order can be obtained at no charge from the BSA Benefits Office.

Recognized Charge

Recognized Charge is determined based on if the provider is in-network or out-of-network.

- In-network service is based on the negotiated rate.
- Out-of-network service is based on the lesser of (a) what the provider bills or (b) the reasonable amount rate.

Refer to the Certificate of Coverage for additional information.

Second Surgical Opinion

Second surgical opinions are based on the terms of each program. You must call the telephone number shown on your medical identification card to obtain the procedures for a second surgical opinion.

MISCELLANEOUS

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, a serious health condition, or to care for a family member with a serious health condition or a newborn or adopted child, you may continue your medical coverage during the term of the approved leave from the starting date of your leave by paying the required employee premiums. Participants on approved military leave may drop medical coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop medical coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

TERMINATION OF COVERAGE

Medical coverage for active employees, retirees, participants receiving LTD Plan benefits, and your covered dependents will cease on the earlier of the date your employment terminates, or (if applicable) LTD Plan benefits terminate, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Medical coverage for terminated employees, who continue benefits under COBRA or DWMBP, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse or same-sex domestic partner also ceases upon your divorce or dissolution of domestic partnership. You have the option to terminate dependent coverage if you are legally separated.

If your coverage under this Medical Plan ends, you and your covered dependents may request a certificate from the BSA Benefits Office that shows your period of coverage under the Medical Plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this Medical Plan.

As of January 1, 2015, a retiree will cease to be a participant in the BSA Medical Plan as of the date the participant becomes Medicare-Eligible, unless such participant resides outside the United States. Each covered dependent will cease to be a participant in the BSA Medical Plan as of the date the participant becomes Medicare-Eligible, unless such participant resides outside the United States.

Effective as of January 1, 2015, in the case of a former Employee receiving LTD Plan benefits under the BSA Long Term Disability (LTD) Plan, such former Employee will cease to be covered under the BSA Medical Plan as of the date such individual becomes Medicare-Eligible, unless such former Employee was approved for such BSA LTD Plan benefits prior to January 1, 2009 (January 1, 2012, in the case of a former Employee who was covered under a collective bargaining agreement between the Employer and the International Brotherhood of Electrical Workers ("IBEW")). Each covered dependent will cease to be a participant under the BSA Medical Plan as of the date such individual becomes Medicare-Eligible unless the former Employee was approved for such BSA LTD Plan benefits prior to January 1, 2009 (January 1, 2012, in the case of a former Employee who was covered under a collective bargaining agreement between the Employer and the IBEW).

Please note that your coverage will terminate immediately if you commit an intentional misrepresentation or fraud on the Medical Plan.

Your coverage will also end on the date the Employer discontinues the Medical Plan.

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Medical Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Medical Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed previously in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Medical Plan is lost because of the qualifying event. Under the Medical Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Although the COBRA law does not apply to domestic partners, the Employer will extend your domestic partner and his or her children the same options to continue coverage as would apply to your spouse or other dependents. Under the Medical Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Medical Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or same-sex domestic partner of an employee, you will become a

qualified beneficiary if you lose your coverage under the Medical Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your domestic partnership terminates.

Your dependent children will become qualified beneficiaries if they lose coverage under the Medical Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child stops being eligible for coverage under the Medical Plan as a "dependent child."

When is COBRA Coverage Available?

The Medical Plan will offer COBRA continuation coverage to qualified beneficiaries only after the BSA Benefits Office has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the BSA Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the BSA Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the BSA Benefits Office has been notified that one of these events has occurred, notification will be provided to you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of the notice indicated above or the date of the qualifying event, whichever is later, your group medical insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the same medical coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the BSA Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or same-sex domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse, same-sex domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Medical Plan is determined by the Social Security Administration to be disabled and you notify the BSA Benefits Office in a timely manner, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the BSA Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event that would otherwise have resulted in a loss of coverage while receiving 18 months of COBRA continuation coverage due to your termination of employment, your spouse or same-sex domestic partner and your eligible dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Medical Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Medical Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Medical Plan had the first qualifying event not occurred.

COBRA Premium Requirements

You, or your eligible dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Medical Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The BSA Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse, same-sex domestic partner or dependent child: If the BSA Benefits Office is not notified within 31 days of the date of divorce, legal separation, or termination of domestic partnership.
- For a dependent child: If the BSA Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The Medical Plan is terminated for active employees.

The information in this document is intended to provide only a summary of the general provisions of the Medical Plan. Nothing contained herein should be construed as a promise of employment or continued employment, or to constitute contractual obligations. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations.

GENERAL INFORMATION

Name of Plan:	Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan
Type of Benefit:	This benefit is a welfare plan providing benefits for medical coverage.
Effective Date:	January 1, 2017
Name, address, and telephone number of the Plan Sponsor and Plan Administrator: The Plan Administrator has the exclusive right to interpret the Medical Plan and to decide all matters arising under the Medical Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Medical Plan and the SPD issued in connection with the Medical Plan. Benefits under the Medical Plan shall be paid only if the Plan Administrator, or its delegate, in its sole discretion determines that a Participant is entitled thereto. The Plan Administrator has delegated the discretionary authority to make benefit determinations to the Claims and Appeals Administrator.	Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000 (631) 344-8000
Agent for Service of Legal Process:	General Counsel Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000
Plan Sponsor's federal tax identification number:	11-3403915
Plan Number:	501
Plan Year:	January - December
Type of Funding:	This benefit is funded from the general assets of the employer.
Source of Funds:	This benefit is paid for by a combination of employer and employee premiums.

Type of Administration:	Aetna provides claims administration and other services through an administrative contract with the Medical Plan.
Claims and Appeals Administrator:	<u>Aetna</u> 151 Farmington Avenue Hartford, CT 06156 www.aetna.com (855) 586-6961

PRIVACY OF INFORMATION

Your protected health information will not be disclosed without your written authorization, unless such disclosure is permitted by law. Protected health information is individually identifiable information that is maintained relating to the provision of your health care, such as your medical records, claims payment information, and health care visit and treatment patterns.

YOUR RIGHTS UNDER ERISA

As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plans and Benefits

- Examine without charge, at the Plan Administrator's office, all documents governing the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Termination of Coverage and COBRA sections and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group

health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your right under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof, concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance With Your Questions

- If you have any questions about your plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL DESCRIPTION OF MEDICAL PLAN PROGRAMS

The Medical Plan currently offers four programs:

- Three Point of Service programs: Aetna POS Plan 1, Aetna POS Plan 2, Aetna POS Plan 3; and
- A High Deductible Health Plan with a Health Savings Account: Aetna Plan 4 HDHP with HSA, which is only available to active employees who are not eligible for Medicare and their eligible dependents.

Aetna Plans 1 – 3 are Point of Service (POS) programs where you may use physicians and facilities of your choice worldwide.

When you use a provider or healthcare services, you pay for part of the cost of those services yourself in the form of copayments, deductibles, and coinsurance. Aetna's POS network includes not just physicians, but many types of healthcare service providers such as hospitals, laboratories, x-ray facilities, physical therapists, medical equipment providers, out-patient surgery centers, etc. The POS plans provide an incentive for you to get your care from its network of providers by charging you lower copays, deductibles and coinsurance compared to when your care is provided out-of-network. You do not need to select a primary care physician, and referrals to specialists are not required.

Plans 1 – 3 vary based on copayments, deductibles, coinsurance and employee premiums.

Aetna Plan 4 is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) where you may also use physicians and facilities of your choice worldwide.

A High Deductible Health Plan has a higher deductible than most health plans.

An "employee-only" HDHP covers just you. For the purpose of the HDHP, the term "family" plan means a plan that covers you and at least one other person – so both 2-person coverage and coverage for 3 or more people are "family" coverage for the purpose of this plan.

With the HDHP, you first pay a deductible. Your deductible is based on your coverage level ("employee-only" or "family"). Once you pay the deductible for the calendar year, then the medical plan provides coverage for medical care based on the terms of the plan. (The deductible under the HDHP works differently than how it works under Plan 1 – 3 where in those plans you can have coverage for 2 or more people but the individual deductible still applies to each person separately. In the HDHP, if you have coverage for 2 or more people, only the "Family" deductible applies – and there is no individual deductible in this example.)

In the HDHP, the out-of-pocket maximum works the same as under Plans 1 – 3. The "individual" out-of-pocket maximum applies to "employee-only" coverage. The individual out-of-pocket maximum also applies to "family" coverage. If you have "family" coverage under the HDHP, each person can either reach the "individual" out-of-pocket maximum or the "family" can reach the "family" maximum each calendar year. Once the applicable out-of-pocket maximum is reached, the plan pays 100% of covered expenses. The out-of-pocket maximum includes copayments, deductibles and coinsurance.

The HDHP also has a Health Savings Account (HSA). See the "Summary of Health Savings Account Rules" section for more information on the HSA.

SUMMARY OF HEALTH SAVINGS ACCOUNT RULES

The Health Savings Account (HSA) is used to pay qualified medical expenses. You must be enrolled in the High Deductible Health Plan (HDHP) to participate in the HSA.

An “employee-only” HDHP covers just you. For the purpose of the HDHP, the term “family” plan means a plan that covers you and at least one other person – so both 2-person coverage and coverage for 3 or more people are “family” coverage for the purpose of this plan.

Contributions to the HSA

If you are enrolled in the HDHP at the beginning of the calendar year, BSA will contribute \$500 to the HSA on your behalf if you have “employee-only” coverage and \$1,000 on your behalf if you have “family” coverage. Such amounts will be prorated if you begin participation in the HDHP later in the calendar year.

You may also contribute to the HSA on a pre-tax basis through paycheck deductions throughout the calendar year or on an after-tax basis. The minimum annual contribution is \$300. You can deposit money into the HSA at any time and in any amount up to the annual limit as long as you are eligible for the HSA. If you are no longer in the HDHP, then you no longer can contribute to the HSA.

The Internal Revenue Service (IRS) sets the contribution limits each year. The contribution limits include the amount contributed by BSA. The annual limits for 2016 are:

<u>Coverage</u>	<u>Maximum Total 2016 Contribution</u>	<u>BSA 2016 Contribution</u>	<u>Maximum 2016 Employee Contribution</u>
“Employee-only”	\$3,350	\$ 500	\$2,850
“Family”	\$6,750	\$1,000	\$5,750

If you are 55 or older you can contribute an additional \$1,000 to the HSA during 2016. This is a “catch-up” contribution. You can do this each year that you are eligible for the HSA. Once you enroll in or become eligible for Medicare, you are no longer permitted to make these contributions.

If you participate in the HDHP for less than a full calendar year, the IRS has rules regarding the amount you can contribute to the HSA and potential taxes on such contributions.

The IRS also has rules that apply if you contribute more than the allowable amount to the HSA.

Additional Eligibility Rules

- You cannot be enrolled in both the Health Care Reimbursement Account and the HSA.
- If you are enrolled in Tricare (through the military) you’re not eligible for the HSA.
- If you receive care from the Veterans Administration, that may affect your HSA eligibility.

Using The Money In Your HSA

You may use the money that is in the HSA to pay for out-of-pocket qualified medical expenses that are not paid by the medical and dental programs. Copayments, deductibles, coinsurance and other out-of-pocket costs such as, vision care, prescription drugs, and more,

are the types of expenses qualified for payment from the HSA. Such expenses can be for you, your spouse and, in general, a dependent you can claim as an exemption on your tax return. You may use the HSA for qualified medical expenses for your spouse and other eligible dependents even if they are not enrolled in the HDHP with you.

You may either pay for your qualified medical expenses from your HSA by using a HealthHub/PayFlex debit card or by withdrawing the HSA funds to reimburse yourself for qualified medical expenses previously paid through another method.

It is important that you save your receipts and Explanation of Benefits (EOB) notices so that you have proof of such qualified medical expenses in case you are audited by the IRS.

You do not need receipts to take withdrawals from your HSA, but withdrawals from the HSA are tax-free only if they pay for qualified medical expenses. If you use the money in the HSA for non-eligible expenses, you will owe income taxes on that withdrawal – and possibly a penalty.

You determine when you want to spend the HSA funds. There is no time limit by which you must spend the money in your HSA.

Investing

The money in your HSA earns tax-free interest.

In addition, once you reach a certain balance in your account, you may choose from an Aetna's list of mutual funds and invest your HSA money. There are fees associated with such mutual fund investments.

Portability

HSAs are portable. This means that you retain the money in your HSA even if you terminate employment. There is no “use-it-or-lose-it” rule with HSAs. If you don't use the HSA funds, they remain in your HSA each year.

Additional Information

The HSA has many additional features, requirements and restrictions based on IRS rules.

Additional information is available through:

- IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) at <https://www.irs.gov/pub/irs-pdf/p969.pdf>
- IRS Publication 502 (Medical and Dental Expenses) at <https://www.irs.gov/pub/irs-pdf/p502.pdf>
- BSA Benefits Office website at www.bnl.gov/hr/Benefits
- PayFlex website at www.payflex.com

EMPLOYEE PREMIUMS (January 1, 2017)

Coverage	AETNA POS PLAN 1							
	Monthly Premium				Monthly Premium (52 Pay Periods)			
	Annual Base Salary				Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1-PERSON	\$ 144.29	\$ 192.96	\$ 234.69	\$ 276.41	\$ 33.30	\$ 44.53	\$ 54.16	\$ 63.79
2-PERSON	\$ 301.41	\$ 400.67	\$ 487.30	\$ 573.94	\$ 69.56	\$ 92.46	\$ 112.45	\$ 132.45
3 OR MORE	\$ 395.91	\$ 532.68	\$ 647.86	\$ 763.03	\$ 91.36	\$ 122.93	\$ 149.51	\$ 176.08

Coverage	AETNA POS PLAN 2							
	Monthly Premium				Monthly Premium (52 Pay Periods)			
	Annual Base Salary				Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1-PERSON	\$ 121.83	\$ 158.54	\$ 200.26	\$ 241.98	\$ 28.11	\$ 36.59	\$ 46.21	\$ 55.84
2-PERSON	\$ 252.96	\$ 329.19	\$ 415.82	\$ 502.45	\$ 58.38	\$ 75.97	\$ 95.96	\$ 115.95
3 OR MORE	\$ 336.30	\$ 437.65	\$ 552.82	\$ 667.99	\$ 77.61	\$ 101.00	\$ 127.57	\$ 154.15

Coverage	AETNA POS PLAN 3							
	Monthly Premium				Monthly Premium (52 Pay Periods)			
	Annual Base Salary				Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1-PERSON	\$ 81.43	\$ 114.64	\$ 156.54	\$ 198.44	\$ 18.79	\$ 26.46	\$ 36.12	\$ 45.79
2-PERSON	\$ 169.08	\$ 238.03	\$ 325.03	\$ 412.04	\$ 39.02	\$ 54.93	\$ 75.01	\$ 95.09
3 OR MORE	\$ 224.79	\$ 316.45	\$ 432.12	\$ 547.79	\$ 51.87	\$ 73.03	\$ 99.72	\$ 126.41

Coverage	AETNA PLAN 4 HDHP WITH HSA							
	Monthly Premium				Monthly Premium (52 Pay Periods)			
	Annual Base Salary				Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1-PERSON	\$ 56.08	\$ 92.18	\$ 133.66	\$ 175.91	\$ 12.94	\$ 21.27	\$ 30.84	\$ 40.59
2-PERSON	\$ 92.72	\$ 168.16	\$ 254.59	\$ 341.03	\$ 21.40	\$ 38.81	\$ 58.75	\$ 78.70
3 OR MORE	\$ 123.29	\$ 223.59	\$ 338.51	\$ 453.44	\$ 28.45	\$ 51.60	\$ 78.12	\$ 104.64

Note: Premium costs are subject to change.

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RETIREE PREMIUMS
(January 1, 2017)

(Non-Medicare Eligible Retirees and Their Covered Dependents)

Category	Aetna POS Medical Program	2016 Premium as a Percent of Medical Program Cost	2016 Monthly Premium		
			One Person	2 People	3 or More People
<ul style="list-style-type: none"> Former non-IBEW employees who retired before 1/1/02 Former IBEW employees who retired before 1/1/04 	Plan 1	30%	\$260.76	\$541.45	\$719.84
	Plan 2		\$250.33	\$519.77	\$691.02
	Plan 3		\$237.18	\$492.47	\$654.73
<ul style="list-style-type: none"> Former non-IBEW employees who were hired before 1/1/11 and retired after 12/31/01 Former IBEW employees who were hired before 1/1/11 and retired after 12/31/03 	Plan 1	40%	\$347.68	\$721.93	\$959.79
	Plan 2		\$333.77	\$693.03	\$921.36
	Plan 3		\$316.24	\$656.63	\$872.97
<ul style="list-style-type: none"> All employees hired on or after 1/1/11 who retire 	Plan 1	50%	\$434.61	\$902.42	\$1,199.74
	Plan 2		\$417.21	\$866.29	\$1,151.71
	Plan 3		\$395.30	\$820.79	\$1,091.22

Note: Premium costs are subject to change.

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RETIREE PREMIUMS
(January 1, 2017)

**(Medicare-Eligible Retirees and Their Covered Dependents
Residing Outside the United States)**

Category	Aetna POS Medical Program	2016 Premium as a Percent of Medical Program Cost	2016 Monthly Premium		
			One Person	2 People	3 or More People
<ul style="list-style-type: none"> Former non-IBEW employees who retired before 1/1/02 Former IBEW employees who retired before 1/1/04 	Plan 1	30%	\$121.49	\$243.15	\$412.91
	Plan 2		\$116.63	\$233.42	\$396.40
	Plan 3		\$110.55	\$221.27	\$375.75
<ul style="list-style-type: none"> Former non-IBEW employees who were hired before 1/1/11 and retired after 12/31/01 Former IBEW employees who were hired before 1/1/11 and retired after 12/31/03 	Plan 1	40%	\$161.98	\$324.20	\$550.55
	Plan 2		\$155.50	\$311.23	\$528.53
	Plan 3		\$147.40	\$295.02	\$501.00
<ul style="list-style-type: none"> All employees hired on or after 1/1/11 who retire 	Plan 1	50%	\$202.48	\$405.25	\$688.19
	Plan 2		\$194.38	\$389.04	\$660.66
	Plan 3		\$184.26	\$368.78	\$626.25

Note: Premium costs are subject to change.

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LTD PLAN PARTICIPANT PREMIUMS
(January 1, 2017)

**(Non-Medicare Eligible Participants Who Are Receiving BSA Long Term Disability (LTD)
Plan Benefits and Their Covered Dependents)**

Category	Aetna POS Medical Program	2016 Premium as a Percent of Medical Program Cost	2016 Monthly Premium		
			One Person	2 People	3 or More People
<ul style="list-style-type: none"> Former IBEW who were approved for BSA LTD Plan benefits after 12/31/11 and are receiving such benefits 	Plan 1	30%	\$260.76	\$541.45	\$719.84
	Plan 2		\$250.33	\$519.77	\$691.02
	Plan 3		\$237.18	\$492.47	\$654.73
<ul style="list-style-type: none"> Former non-IBEW employees who were approved for BSA LTD Plan benefits after 12/31/08 and are receiving such benefits 	Plan 1	40%	\$347.68	\$721.93	\$959.79
	Plan 2		\$333.77	\$693.03	\$921.36
	Plan 3		\$316.24	\$656.63	\$872.97
<ul style="list-style-type: none"> Former non-IBEW employees who were approved for BSA LTD Plan benefits before 1/1/09 and are receiving such benefits Former IBEW employees who were approved for BSA LTD Plan benefits before 1/1/12 and are receiving such benefits 	Plan 1	0%	\$0.00	\$0.00	\$0.00
	Plan 2		\$0.00	\$0.00	\$0.00
	Plan 3		\$0.00	\$0.00	\$0.00

Note: Premium costs are subject to change.

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LTD PLAN PARTICIPANT PREMIUMS
(January 1, 2017)

(Medicare-Eligible Participants Who Are Receiving BSA Long Term Disability (LTD) Plan Benefits and Their Covered Dependents Residing Outside the United States)

Category	Aetna POS Medical Program	2016 Premium as a Percent of Medical Program Cost	2016 Monthly Premium		
			One Person	2 People	3 or More People
<ul style="list-style-type: none"> Former IBEW employees who were approved for BSA LTD Plan benefits after 12/31/11 and are receiving such benefits 	Plan 1	30%	\$121.49	\$243.15	\$412.91
	Plan 2		\$116.63	\$233.42	\$396.40
	Plan 3		\$110.55	\$221.27	\$375.75
<ul style="list-style-type: none"> Former non-IBEW employees who were approved for BSA LTD Plan benefits after 12/31/08 and are receiving such benefits 	Plan 1	40%	\$161.98	\$324.20	\$550.55
	Plan 2		\$155.50	\$311.23	\$528.53
	Plan 3		\$147.40	\$295.02	\$501.00
<ul style="list-style-type: none"> Former non-IBEW employees who were approved for BSA LTD Plan benefits before 1/1/09 and are receiving such benefits Former IBEW employees who were approved for BSA LTD Plan benefits before 1/1/12 and are receiving such benefits 	Plan 1	0%	\$0.00	\$0.00	\$0.00
	Plan 2		\$0.00	\$0.00	\$0.00
	Plan 3		\$0.00	\$0.00	\$0.00

Note: Premium costs are subject to change.

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**DWMBP PREMIUMS
(January 1, 2017)**

(DWMBP Participants and Their Covered Dependents)

	2016 Monthly Premium
During 1 st year	Employee Premiums
During 2 nd year	One-half of COBRA Premiums
After 2 nd year following termination of employment	Coverage can be continued by paying COBRA Premiums

Note: Premium costs are subject to change.

**COBRA PREMIUMS
(January 1, 2017)**

(COBRA Participants and Their Covered Dependents)

Medical Program	2016 Monthly Premium		
	One Person	2 People	3 or More People
Aetna POS Plan 1	\$886.59	\$1,840.93	\$2,447.76
Aetna POS Plan 2	\$851.11	\$1,767.22	\$2,349.48
Aetna POS Plan 3	\$806.40	\$1,674.41	\$2,226.08

COBRA premiums include a 2% administrative fee.

Note: Premium costs are subject to change.

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